Transforming mental health systems globally: principles and policy recommendations

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A burgeoning mental health crisis is emerging globally, regardless of each country's human resources or spending. We argue that effectively responding to this crisis is impeded by the dominant framing of mental ill health through the prism of diagnostic categories, leading to an excessive reliance on interventions that are delivered by specialists; a scarcity of widespread promotive, preventive, and recovery-oriented strategies; and failure to leverage diverse resources within communities. Drawing upon a series of syntheses, we identify five principles to transform current practices; namely, address harmful social environments across the life course, particularly in the early years; ensure that care is not contingent on a categorical diagnosis but aligned with the staging model of mental illness; empower diverse front-line providers to deliver psychosocial interventions; embrace a rights-based approach that seeks to provide alternatives to violence and coercion in care; and centre people with lived experience in all aspects of care. We recommend four policy actions which can transform these principles into reality: a whole of society approach to prevention and care; a redesign of the architecture of care delivery to provide a seamless continuum of care, tailored to the severity of the mental health condition; investing more in what works to enhance the impact and value of the investments; and ensuring accountability through monitoring and acting upon a set of mental health indicators. All these actions are achievable, relying—for the most part—on resources already available to every community and country. What they do require is the acceptance that business as usual will fail and the solutions to transforming mental health-care systems are already present within existing resources.

Introduction

The COVID-19 pandemic has presented an historic opportunity for countries to reimagine their response to the mental health needs of their populations. A mental health crisis, reflected by the rising prevalence of mental illnesses and the large unmet need for care, was evident even before the pandemic. The crisis disproportionately affects those on the margins of society, in particular low-income groups and indigenous communities, LGBTQ+ people, underserved minority groups, and those exposed to the traumas of war or impacted by climate-related events. Young people are especially threatened because many mental illnesses emerge during this developmentally sensitive phase of the life course.[1] This crisis is fuelled by multiple forces: an increase in risk factors, in particular social and economic determinants potentiated by poverty and conflict; the erosion of protective factors, notably the decline of social connectedness as a result of polarisation and rising inequality; and the failure of health-care systems to effectively address mental health conditions. The pandemic has exacerbated this crisis, and climate change is already a powerful amplifier of these forces.[2,3]

The scarcity of mental health professionals, particularly in low-resource settings,[4] and inadequate investment in services and research,[5] are often identified as the core reasons for the global mental health crisis. The solution is often thought to lie in more money and mental health professionals. Remarkably, however, despite the amount of money spent on mental health care, the availability of mental health professionals in high-income countries, or mental health research as currently imagined, the crisis has not eased. As an example, most metrics reflecting mental ill health have worsened in the USA, despite having more mental health resources per person than almost any other country, and spending over US$20 billion on research in the past two decades.[6] A similarly grim picture emerges for mental health indicators in many other high-income countries, in stark contrast to progress in other domains of medicine. We argue that this status quo is the real crisis of mental ill health globally.

Business as usual has failed and will continue to do so. A reimagined approach to mental health requires us to interrogate a set of core assumptions: those underlying our understanding of mental wellbeing and mental health conditions and how we respond to these conditions. We need to reconsider the relationship between mental health and the flourishing field of public health, which embraces diverse perspectives of behavioural sciences, economics, and social policy and has driven down the burden of a range of other health conditions over the past century.[7] There is growing acknowledgment that a singular, structural challenge has been the narrow dichotomous framing of mental ill health through the prism of diagnosed mental disorders. This framework has dominated the field for around half a century, ever since psychiatry adopted a monocausal mental model, which shaped a reductionistic approach to nosology with substantial implications for prevention and care.[8]

The limitation of this approach is the fact that, although most diagnoses of somatic health conditions are based on diagnostic tests, psychiatric diagnoses are based predominantly on clusters of self-reported symptoms. There were structural flaws in this approach from the outset, as the diagnostic categories were based on what academic psychiatrists in high-income countries saw in

their specialised clinics, thus limiting their generalisability to presentations of mental illness in the global context. Nonetheless, this new vision of psychiatry was driven by the concerns regarding the perceived lack of empiricism of the prevailing approaches, characterised by imprecise categories of mental health conditions and care models which were dominated by insight-oriented psychotherapies for common mental health conditions or social interventions for severe mental illnesses.[8] The architects of the new system hoped that adopting a classification of mental disorders would lead to solutions on a par with other medical conditions, an enthusiasm understandably fuelled by advances in understanding the biological basis of medical conditions including neuropsychiatric diseases linked to syphilis and pellagra, and the serendipitous discovery of antipsychotic medications which transformed the lives of people with psychoses.

Disappointingly, 50 years on, we still do not have a single biological finding that can be applied to diagnose any mental illness, nor a single new therapeutic agent or target for prevention. Yet, this reductionist framework continues to prevail, privileging certain types of providers (eg, mental health specialists), interventions (eg, medications), delivery settings (eg, hospitals), particular perspectives of recovery (eg, focused on clinical symptoms), and particular perspectives on research priorities (eg, focused on biological mechanisms). As a result, this privileging narrows the approaches in which psychiatrists and other specialist mental health providers are typically trained and accultured. One example of the consequences of this narrowed perspective is that, even though a wide range of social and psychological interventions are known to work for the prevention and care of mental ill health, medication is the most widely accessible (and in many populations, only accessible) intervention, in part fuelled by the collusion of the health-care system with commercial interests.[9] Although these power imbalances are not dissimilar to those in other branches of medicine, where they are also being critiqued, this framing is particularly unsuited for mental illness due to the far larger complexity of the pathways that underpin mental illness. From a population perspective, there seems to be almost no correlation between the density of mental health professionals, proxies for clinical interventions, and the prevalence or incidence of mental illnesses.

There have been critiques of this narrow biomedical framing since its inception, notably the World Health Forum report in 1995[10] and the *World Health Report* examining mental health in 2001.[11] A series of major reports have specifically attended to various aspects of the global mental health crisis, including three *Lancet* Commissions concerned with mental health,[12–14] the Disease Control Priorities initiative,[15] and WHO's *World Mental Health Report*[16] and Commission on non-communicable diseases,[17] which all call for a reimagining of mental health policy and practice. The Lancet *Commission on Global Mental Health and Sustainable Development* called for acknowledgment of the central role of social environments in the early years of life in shaping brain development and mental health, explicit recognition of the dimensional nature of mental health conditions, and a rights-based approach to prevention and care.[12] The *Lancet*–World Psychiatric Association Commission on depression, which addressed the leading cause of mental illness-related disease burden, drew on these insights to emphasise the need for united action by people with lived experience of mental illness, their families and communities, practitioners, researchers, and policy makers to dispel myths about mental ill health and depression, and apply what works in prevention and recovery.[13] The Lancet *Commission* on *Ending Stigma and Discrimination in Mental Health*[14] identified the central role of people with lived experience as key to addressing the pervasive stigma and discrimination against people with mental health conditions and their carers, both formal and informal.

At the heart of these reports is the need to adopt a shift towards a biopsychosocial framework that explicitly embraces the interaction of biological, psychological, and social factors in the shaping of a continuum of mental health across the life course. In this Health Policy, we seek to synthesise these recommendations by identifying five key principles needed to embrace the biopsychosocial framework (figure 1), and four policy actions that will be needed to realise these principles.

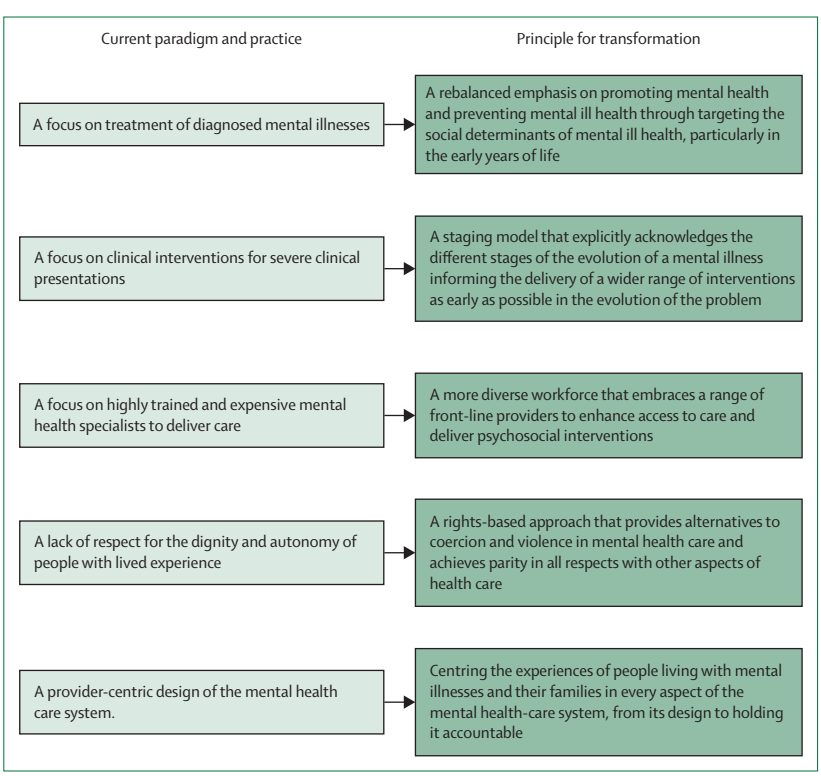

Figure 1: **Principles for transforming mental health globally**

Principle 1: target harmful social environments across the life course

The first principle requires a shift in focus, away from the treatment of diagnosed mental health conditions, to an equal, or even higher, priority for the prevention of mental health problems and the promotion of mental health. This shift is important for several reasons. First, even under optimal conditions, treatment alone will never be sufficient to reduce the global burden of mental ill health. For example, even high levels of coverage of available treatments can only reduce the global burden of depression by one-third,[18] and there is no evidence to support an association between increasing coverage of treatment of mental ill health and reduction of the population burden of mental health conditions in any context. Second, interventions that prevent mental health conditions and promote mental health are essential adjuncts to treatment.[19,20] Third, there is now robust evidence supporting the effectiveness of a range of interventions to prevent mental health conditions and promote mental health.[21,22]

Attempting to reduce the number of people with mental ill health without combating adverse social and economic conditions would be the equivalent of tackling cancer with no regulations on cigarette smoking, or trying to reduce infectious disease without investments in public sanitation. Social and economic conditions shape the mental health of populations and this reality shows the true value of good mental health for individuals, families, communities, and governments as an intrinsic part of human development and quality of life.[16,23,24] Crucial to this principle is reframing the assumption that social and economic conditions, which are the most robust risk factors for developing mental ill health, form a set of intractable challenges.[24] Although structural factors such as poverty, inequality, and gender are powerful distal determinants of mental health, these determinants influence mental health across the life course through pathways that involve a range of more proximal intermediate factors, many of which are modifiable. For example, the effects of poverty are proximally mediated through household income volatility and food insecurity, which can be effectively addressed through cash transfers, food subsidies, and housing support.[25,26] Similarly, the effects of gender inequality are proximally mediated through disempowerment of women and increased risk of intimate partner violence, which can be addressed through implementing laws that enshrine equality for women (such as in the workplace) and a range of strategies to prevent gender-based violence.[27]

This principle is supported by the identification of other pathways and mechanisms by which social and economic determinants influence mental health, offering yet more clearly defined targets for interventions. For example, there is growing evidence for the way in which poverty precipitates negative affective states: these lead to risk-averse and habitual behaviours, rather than goal-directed behaviours, in turn maintaining poverty traps.[28] Interventions that both address poverty and these cognitive, affective, and behavioural mechanisms have the potential to yield sustained economic and mental health benefits. For example, cognitive behaviour therapy delivered in conjunction with cash transfers has been shown to yield both short-term and long-term benefits for young men in Liberia who are at high risk of mental ill health.[29] Similarly, initiatives that support the empowerment of women and communities and the reduction of intimate partner violence are also likely to result in improved mental health and wellbeing.[27,30]

There are several compelling reasons for adopting a life course approach and intervening early to target these factors. Given the rich epidemiological evidence showing that two-thirds of mental illnesses have an onset before the age of 24 years, a developmentally informed approach recognises the profound influence of environments in the first two decades of life on shaping brain development and mental health.[1] Most notable of these risk factors are adverse childhood experiences including childhood maltreatment, neglect, and deprivation, which are highly modifiable with interventions such as income support, parental leave, access to quality antenatal care, promoting responsive parenting, care for maternal depression, and addressing intimate partner violence.[31] During the school years, effective interventions promote a positive school environment, for example through enhancing social capital, reducing bullying, and building social-emotional competencies.[32] There are also effective interventions beyond the early years, including: couples' interventions to reduce intimate partner violence; workplace programmes to increase job security, prevent bullying, and increase autonomy and decision making; programmes for the promotion of social connectedness and reduction of loneliness; prevention and management of chronic diseases; and social protection against economic and health risks.[13]

Principle 2: care is determined by a person's needs, not their diagnosis

Current care models are dominated by the need to establish a diagnosis to offer treatment. The use of contemporary classification systems, in which a person is classified as either having a specific mental health condition (eg, depressive disorder, schizophrenia, or bipolar disorder) or not, is problematic for many reasons, in particular perpetuating the conflation of mental health conditions with the criteria used to diagnose and classify them.[33] This classification system is premised on group averages that inform how groups of individuals differ from one another but provide little acknowledgment of the heterogeneity within categories, the blurred boundaries between categories, and the dynamic changes a single individual might experience at multiple points in time.[34] The heterogeneity between how different people

experience the same mental health condition can be so great that it is possible for two people to have the diagnosis of depression and not have a single symptom in common. However, the current framework of categorical diagnoses dominates the mental health landscape, leading to treatments and research that fail to capture differences in individual experiences, as exemplified in the so-called therapist's dilemma—the translation of group-average research evidence to individual-level clinical care.[35]

Diagnosis-focused approaches also miss opportunities for interventions in the emergent preclinical stages of a mental illness; these approaches deflect attention from person-centred care by emphasising narrowly defined biomedical interventions applied in a one size fits all approach to people with the same diagnostic category, with little attention to an individual's unique needs and psychosocial determinants.[14] An alternative approach is the staging model, which explicitly acknowledges the different stages of the evolution of a mental health condition in a person.[36] This approach has parallels to other fields of medicine ranging from risk and severity classifications for metabolic disorders to oncology, where staging is vital to establish the appropriate intervention and to guide patients' decision making for their care.

In the context of mental health, the staging model covers: experiences of mild, non-specific symptoms or of attenuated syndromes with minimal impairment of functioning; experiences of a discrete mental health condition (eg, a first episode meeting criteria for major depressive disorder with its associated functional impairment); remitting and relapsing course of a mental health condition (eg, repeated episodes); and a persistent experience of a mental health condition associated with enduring disability.[13,37] A staging model has implications for the range of types of care, who can provide care, what care is provided, and where it is provided (principle 3). Different interventions are prioritised at each stage, from early intervention to acute episode interventions, and recovery interventions in subsequent stages, with individual tailoring at each stage (principle 5).

Principle 3: empower front-line workers to deliver evidence-based psychosocial interventions

The third principle addresses where, how, and by whom care is delivered. The current model has been dominated by specialty care, siloed from other components of the health-care system. Inpatient care is often provided in hospitals or wards that are separate from general health services, and mental health outpatient care is disconnected from primary care and social welfare services. Most care is focused on acute psychiatric episodes, with a historical neglect of early interventions or indicated prevention and of long-term recovery-focused interventions. In short, the current model of mental health care is only an incremental advance of the institutional model that dominated the landscape of care for over a century. This model of care is associated with a range of demand-side and supply-side barriers, such as the reluctance to seek help from specialists until a condition is severe, the high cost of specialist clinical care, and the inequitable distribution of specialist providers.

Principle 3 calls for a massive expansion of the workforce for mental health care, embracing a range of non-specialist providers. At the heart of this principle is the large body of implementation science showing that such non-specialist practitioners (eg, community health workers) and community members (eg, teachers, social service providers, religious leaders, and peers) can effectively deliver brief psychosocial interventions for a range of mental health conditions, in the context of sustained collaboration with specialist care.[38–43] Such interventions can be delivered within the community, including in primary care, schools, and in people's homes. Among the diverse categories of non-specialist providers, those with lived experience occupy a special place. Peer-led service providers are better positioned than other professional services to understand the vulnerabilities and corresponding needs of their peers, through applying their own lived experiences and understanding of how various levels of care could offer improved outcomes.[44] The deployment of front-line providers should ideally be done through a collaborative care delivery model, in partnership with mental health specialists[45–47] who can offer supervision, support, and referral pathways.

Apart from expanding access to lower-cost, community-based skilled providers, task-sharing has many other less tangible benefits, including promoting the self-efficacy of front-line providers, leveraging social connectedness as a key ingredient for recovery, offering long-term support (which is crucial for enduring mental health disorders), and reducing stigma associated with mental health care through integration with social and physical health-care needs.[48] Thus, such front-line providers should not be seen as stop-gaps to fill the void until more specialists can be trained, but rather as full members of a comprehensive care team to improve proactive case finding, case management, promote adherence and treatment engagement, delivery of psychosocial interventions, and successful navigation to other social, economic, and community services.[49] Task-sharing is also a way to engage non-health sectors in mental health care, in particular schools, child welfare and social services, disability related services, and law enforcement. Task-sharing is an extension of the existing mental health-care system, expanding its footprint deep into the community, including a strong interface with primary health care, addressing unmet needs, and reducing disparities in mental health care. Thus task-sharing is relevant to all countries, regardless of their specialist resources (although more so in contexts where specialist resources are scarce) and must incorporate a clearly defined

strategy for coordination with specialised care and primary health care to allow for a seamless journey for people with mental health conditions.

Scaling up front-line worker delivered psychosocial interventions will need to address challenges related to motivating front-line workers—eg, through adequate training, recognition, and remuneration. In addition, orthodox approaches to training, supervision, and quality assurance that rely on specialist-led, in-person formats need to be replaced by digital or hybrid formats,[50,51] leveraging the growing evidence base supporting the feasibility, acceptability, and effectiveness of digital tools and technologies to build workforce competencies to deliver quality assured evidence-based psychosocial interventions.[52] Additionally, digital apps to promote self-care, remotely monitor mental health, and support the practice of skills learned during therapy could offer a valuable supplement to human provider care.[53]

Principle 4: embrace a rights-based perspective for mental health care

For too long, people with lived experience of mental health conditions and their families have been discriminated against in employment, education, and judicial systems.[14] Within the health-care system, there is a history of neglecting individuals with mental health conditions and ignoring their physical health needs, contributing to premature mortality.[12] This neglect is especially true for women, who are more likely to have physical diseases associated with mental ill health.[54] Within mental health-care systems, people with mental health conditions have been denied dignity and basic human rights. The reluctance to seek help from mental health professionals is not only attributable to the narrow biomedical framing being misaligned with the personal narrative of mental ill health, but also because of the long history of coercion, incarceration, and excessive medication associated with mental health care.[14] The fourth principle requires that discrimination is eliminated and human rights protected through implementing alternatives to violence and coercion in mental health care and ensuring that all aspects of mental health care are aligned with the same quality and rights associated with physical health care.[55]

There are several strategies to realise this principle. The WHO QualityRights resource can guide clinicians, health system administrators, and service users and their families to work together to monitor, evaluate, and take necessary actions to protect against rights violations.[56] All members of care teams should be trained in strategies to reduce stigma. As one example, the *Responding to Experienced and Anticipated Mental Health-Related Discrimination* initiative[57] includes training for medical students to evaluate and address stigma among service users and is currently being adapted for training mental health specialists to be allies in reducing stigma. The changes need to be enabled by cooperative local action including people with the lived experience and families. Legal protections for people living with mental health conditions must be strictly enforced. Trained front-line providers, rather than law enforcement officers, should lead the response to mental health emergencies. All crisis admissions must aim to secure supported decision making, in line with the Convention on the Rights of Persons with Disability, with substituted (ie, involuntary) decision making being the last resort and governed by strict, independent oversight and limits.[58] Legal tools such as psychiatric advanced directives established when a person is in symptom remission can help health-care providers make decisions in accordance with a person's wishes.[59]

These aspirations have been embraced by the World Psychiatric Association, which has sponsored a programme on supporting alternatives to coercion in mental health care and advocated for intervening early in the course of mental health conditions, as well as support for recovery for those with longer-term conditions, to reduce the risk of acute crises.[55] The recommendations note that practitioners, service users, and advocates share the understanding that coercion is overused and set out a range of changes possible in policy, service design, workforce training, and attitudes. The places where human rights violations are more likely to occur should receive particular attention: namely, custodial mental hospitals associated with coercive and violent practices in addition to poor living conditions. It is unacceptable that despite decades-old recommendations and commitments,[11,49] there are still three times as many beds in mental hospitals as in general hospitals and as much as 70% of governmental mental health budget in middle-income countries still goes to mental hospitals.[60] Strategies for deinstitutionalisation, which are represented in earlier principles, need to be implemented urgently.[61,62]

Principle 5: place people with lived experience at the centre of the care system

The prevailing diagnosis-focused model of care is primarily driven by provider perspectives. These perspectives are limited for a variety of reasons noted earlier, not least their poor validity.[63] Despite these reasons, insurance companies, hospital corporations, pharmaceutical companies, mental health specialists, and policy makers continue to use this approach to determine how people living with mental health conditions seek and receive care.[64,65] For example, clinicians and researchers use symptom measures to decide who needs treatment and to judge whether or not that treatment is successful. Yet people with lived experience of mental ill health frequently report that these tools do not capture what matters most for their lives and wellbeing.[66] The final principle emphasises centring the experiences of people living with mental ill health and their families in every aspect of the mental health-care system, from its design to holding it accountable.[67] It is no longer acceptable to consider

people with mental ill health as passive recipients or beneficiaries of treatments or care.[68,69]

This principle can be observed in the movement towards person-centred care in medicine[70,71] and towards patient and public involvement in the co-design, implementation, and quality evaluation of mental health services.[72,73] People with lived experience of mental health must be adequately supported to play a key role in the development of high quality mental health care. This includes alternatives to involuntary treatment and coercion through mental health policies and resource allocation, the design of the mental health-care system, monitoring the quality of specialist care facilities, and promoting supported decision making.[58] There is a particular opportunity to integrate the role of the lived experience in training health-care professionals.[16] For example, when training primary care workers in integrating mental health care, the inclusion of people with lived experience as co-facilitators might lead to more accurate identification of care needs.[74] There are now tools for shared decision-making processes for providers and patients to better incorporate patient preferences.[75] Outcome measurement can be based both on symptoms as well as problems and types of impairment that matter most, such as with the Psychological Outcome Profiles questionnaire.[76] Given that structural interventions such as supportive housing, guaranteed income, and social inclusions have benefits across diagnoses,[24] these must be given at least equal importance to biomedical interventions in mental health care. Ultimately, partnership with people with lived experience can only exist when power imbalances that are biased in favour of mental health professionals are eliminated and when people with lived experience are included in decision-making processes that are meaningful and authentic.

Policy actions

The global burden of mental ill health has proven to be resistant to the prevailing approaches targeting their prevention and care. Building on a series of key syntheses and reports, we argue that the core reason for the failure to effectively reduce the global burden of mental ill health is an excessive reliance on the narrow biomedical framing of mental ill health, through the prism of diagnosed mental disorders, which has dominated research, policy, and practice for the past 50 years. This framing leads to an emphasis on clinical interventions that are delivered by specialists for people with diagnosed disorders, to the exclusion of promotive, protective, preventive, and recovery-oriented strategies using diverse resources within communities. The existing evidence indicates the need for the adoption of a much broader, biopsychosocial framing of mental health and mental illness, a framework which was dominant until the early 1970s. In this Health Policy, we have outlined a series of five principles that better align with the biopsychosocial framework, while also being relevant to practitioners who have been trained in the use of the dominant diagnostic framework. Although many of these have been advocated in the past, they have often been marginalised, resulting in them being either under-resourced or ignored altogether by policy makers. In this final section, we turn to the four specific policy actions that are needed to practically realise these principles.

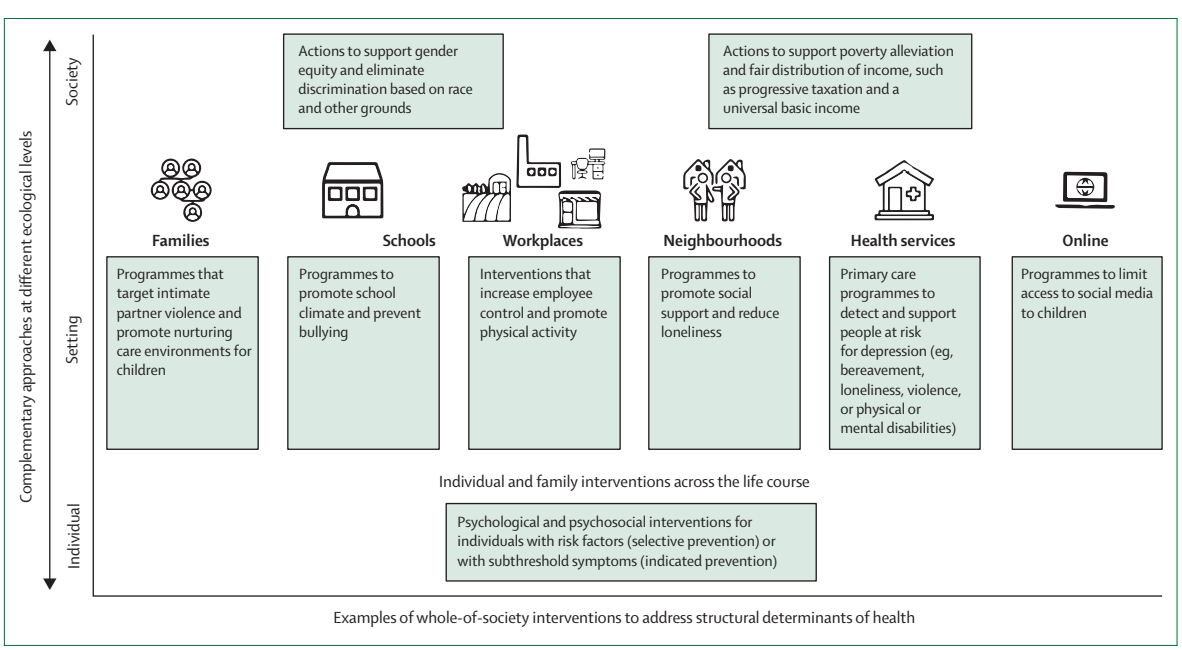

Figure 2: **Whole of society interventions to address structural determinants of health**
Adapted from Herrman and colleagues,[13] by permission of Elsevier.

Whole of society approach to prevention and care

For many years, prevention of mental ill health and promotion of mental health have been recognised as priorities alongside mental health care and we now have the science to guide us on the best way forward.[77,78] A population-level approach, guided by a developmental life course perspective, is needed with actions targeting social, economic, and ecological determinants of mental health (figure 2).[19,24] The major drivers of a whole of society approach are to ensure equity and to shift the attention to the early years of life.[79] An outstanding example of a global convention that enshrines the actions needed is the UN Convention on the Rights of the Child, the most widely ratified human rights treaty in history, which has helped fuel national policies to implement this Convention and transform children's lives around the world.[80] These policies must be translated into investments in effective interventions that promote nurturing environments in childhood and adolescence, and social and economic interventions targeting low-income, disadvantaged, or deprived populations and communities.[81]

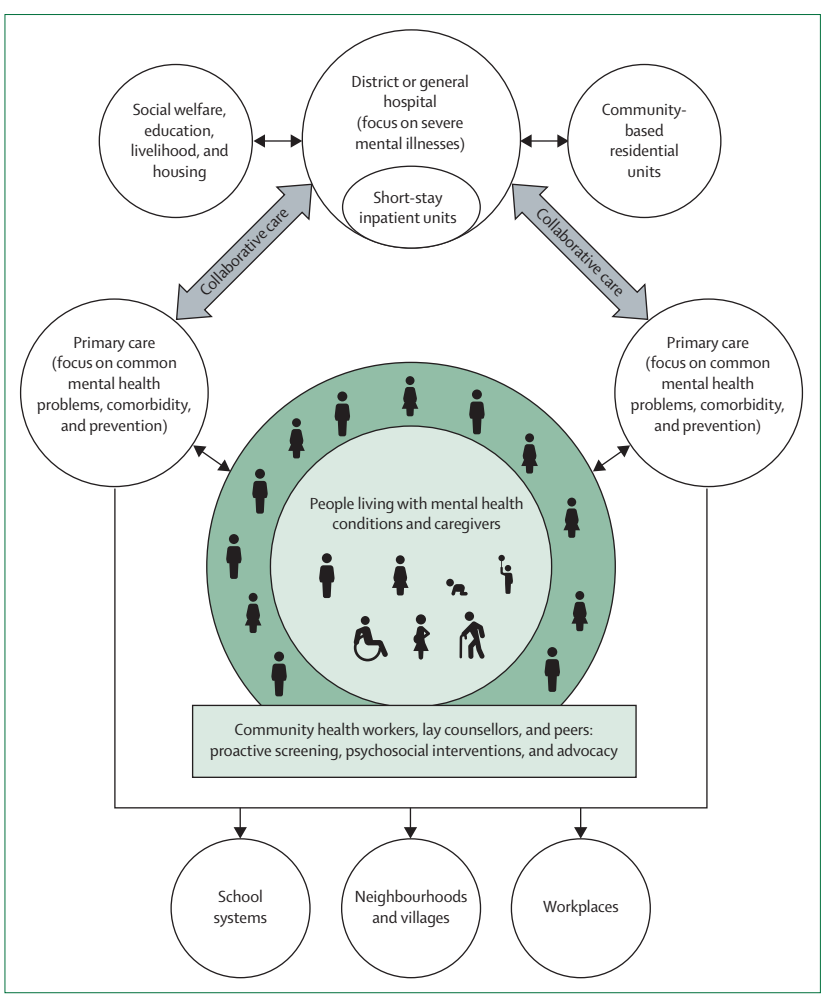

Figure 3: **Architecture of a district mental health-care delivery system**

For people with a mental health condition, sectors other than health need to be actively involved in improving access to care and addressing the consequences of mental ill health (eg, educational institutions, workplaces, law enforcement agencies, social welfare services, and child protection services). This broadening of needs will not only provide care where people are but also provide care which is most appropriate. A rights-based approach can be ensured only with the involvement of civil society organisations. Towards this objective, initiatives that empower individuals, families, and communities are crucial, so that all these stakeholders can have an active role in the implementation of evidence-based prevention and care. There is a special need to engage and empower people and families living with mental health conditions. Employers and businesses are also crucial stakeholders because they not only can promote mental health and wellbeing at work but can also provide resources for mental health activities in the communities they serve.[82]

A whole of society approach, requiring the collaboration of a broad range of government sectors and civil society, presents unique challenges for its stewardship. In most countries, mental health is left within the exclusive prerogative and responsibility of the ministry of health with a resulting focus on treatment and care of disorders. Yet almost all government departments can and should contribute, and there are specific roles for education, social welfare, labour, housing, justice, and environment. A high level inter-ministerial policy group for mental health, coordinated by the ministry of health, is one administrative mechanism to achieve coordinated action. The appointment of a minister for mental health or wellbeing, as some countries have done,[83] is another example of such a policy action—especially when the minister's scope of responsibilities extends beyond the ministry of health. Such national-level stewardship needs to be replicated down to the smallest administrative unit for health programmes—for example, the district or county. Ultimately, at the heart of the whole of society approach is the acknowledgment that mental health is central to human life and development and valued by a range of sectors in society—both for its intrinsic value and for its instrumental value (eg, enabling a range of other social and economic benefits).[12] This deepening of societies' valuing of and commitment to mental health is aligned with the transformation outlined in the 2022 *World Mental Health Report*.[16]

Redesign the architecture of care

For treatment and care, the major goal is to increase equitable service coverage and to ensure the quality and continuity of services.[49] This goal can be achieved by planning for and implementing an optimum mix of services for all stages of mental health conditions and for all segments of the population.[84] The architecture of the care delivery system must recognise the large diversity of

needs across the life course and different types of mental health conditions. The still-unfinished agenda of shifting care from mental hospitals to community-based services must be prioritised, but community-based services must consider two distinct yet overlapping strategies for integration (figure 3).

The first strategy comprises care for severe and acute mental health conditions. We argue that the node for integration for this group must be specialist care and comprise decentralised short-stay inpatient units, ideally located in a general hospital and staffed by nurses and physicians trained in mental health, linked to a network of front-line providers offering community-based support for people who are recovering. The ecosystem of care should also include small, community-based, long-stay facilities that function as sheltered homes for people who have enduring psychosocial disabilities and no place of residence. Recovery programmes and community-based services that empower the service user to take the lead in their own treatment and recovery have positive physical and mental health outcomes.[61] Attention must be paid to the physical environments of inpatient units, which should resemble a space that is dignified and promotes the wellbeing of both service users and facility staff.[85] The second strategy addresses population mental health, which is dominated by mood, anxiety, stress related conditions, and substance-use conditions, staffed by diverse front-line providers working in close coordination with primary care (or paediatric care for children) supported, through collaborative care models, by specialist practitioners (figure 3).

The entire system, comprising both these strategies, must be accountable through the continuing evaluation of the quality of care (eg, metrics related to the use of evidence-based protocols) and impact on the lived experience, moving beyond the current emphasis on simply reporting inputs such as costs and the training of human resources. The reorientation of the architecture of the care delivery system offers a hopeful, evidence-based view of the potential effect of care and support, which prioritises the needs of patients and providers, and leverages existing human and social resources in communities. The ultimate goal is to offer a seamless continuum of care in which mental health is integrated across health-care platforms and sectors beyond health care, and a person is accompanied between sectors to receive interventions tailored to their needs and choices to promote recovery. This goal of comprehensive, integrated, and responsive mental health and social care services is envisioned in WHO's *Comprehensive Mental Health Action Plan 2013–2030*.[49]

Invest more and wisely

The majority of countries fall short of the recommendation for a minimum allocation of 5% of the health budget in low-income and middle-income countries and 10% in high-income countries for mental health.[12,60] Investing more is perhaps the single most influential policy action that countries can take to improve the mental health of their populations, as they committed to do in 2015 when endorsing the UN Sustainable Development Goals.[86] Increased allocations for mental health, beyond the narrow confines of the mental health line item in the health budget, can also be realised in two ways. First, the integration of mental health care for common mental health conditions in primary care should be financed by the general or primary health-care budget (and, similarly, for integration in other sectors). Second, correcting inequities that lie at the root of social and economic determinants of mental health should be resourced by sectors such as child welfare, education, and employers, in line with the whole of society policy action for prevention and care.

However, even in the absence of increased resources, actions can be taken to move the allocation of existing investments away from institutional care, which is neither cost-effective nor person-centred.[15] The immediate imperative is therefore to emphasise spending wisely for better value for money. Effective systems of care require investments commensurate with needs and allocated based on cost-effectiveness, impact, and equity financing.[87] Thus, increased investments need to be made towards supporting community and grassroot actions (including organisations led by and for people with lived experience of mental ill health), which are indispensable components of the care system, to fulfil their potential in the architecture of care. Within health services, resources must be allocated to building the front-line workforce to deliver evidence-based psychosocial interventions.[52] In addition, resources need to be made available to train people outside the health-care system—teachers, emergency care providers, and the public—to promote mental health in the populations they serve. It is important to recognise the limitations of simply training primary care personnel, a strategy that has dominated efforts to integrate mental health into primary care in the past; investments must also be made in building the collaborative care processes necessary for coordinating diverse providers and long-term supervision and support of providers.

Ensure accountability

Although the field of global mental health is replete with guidelines, recommendations, calls to action, and a growing list of commitments, none of these will have a measurable impact without a robust monitoring and accountability mechanism. At the heart of this lack of accountability is the absence of reliable, valid, and sensitive metrics that reflect the mental health of a population and are derived from a set of indicators that are collected routinely, comparable across contexts and over time, reported widely, and actionable. There is no single indicator that can offer a comprehensive assessment of the multiple determinants and outcomes related to mental ill health. Thus, as with many other multifaceted constructs, an index comprising multiple

indicators might offer the most appropriate path forwards. The crucial need for such a metric or index has been advocated for some time by global mental health researchers.[88,89] Without measurement, we cannot hold governments accountable and without accountability, we will not be able to progress population-level mental health as envisaged in the five principles described above.

Countdown Global Mental Health 2030, an initiative led by a global consortium of institutions, is beginning to address this need.[90,91] Countdown's mission is to develop and implement a global monitoring and accountability framework for mental health in keeping with political commitments made within the larger context of the UN Sustainable Development Goals, as well as the WHO Mental Health Action Plan.[88,90,91] Countdown has identified a set of indicators to monitor progress on mental health; indicator domains include determinants of mental health, mental health systems, services, and health outcomes, almost all of which are routinely collected and reported through existing mechanisms. Together, this basket of indicators addresses all the principles and policy actions outlined in this Health Policy. Countdown has already made data available on several selected indicators for all countries.[90]

Conclusion

In conclusion, the global mental health crisis is not solely the result of a scarcity of political will, resources, or knowledge. We propose a shift away from the prevailing categorical framing of mental ill health through the prism of diagnosed mental disorders to a broader, biopsychosocial framework. Five principles guide the implementation of this framework, and four policy actions can transform these into reality. None of these principles are new and all these actions are eminently tractable, relying on resources available to almost all communities and countries. What we need now is an acceptance that business as usual will fail, and that each country should commit to this transformative, population-based vision and invest in planning, implementation, and continuing evaluation of these principles if they are to achieve the goal of reducing the population-level burden of mental health conditions.

Contributors

VP, SS, CL, BK, CK, CS, LK, OC, FC, and HH conceptualised the study and were responsible for investigation, methodology, validation, visualisation and the writing, reviewing, and editing of all versions of the Health Policy. VP supervised the project. KO'N contributed to project administration, visualisation, and the writing, reviewing, and editing of all versions of the Health Policy.

Declaration of interests

VP has received grant funding from the National Institute of Mental Health (NIMC), Grand Challenges Canada, and the Medical Research Council (MRC). VP receives book royalties from Oxford University Press and Cambridge University Press. VP has received consulting fees from Modern Health and Google. HH has received support for attending meetings from the World Psychiatric Association. HH also has leadership roles with Orygen Australia, citiesRISE New York, and Kindred Collaborative Australia. LK has received grant funding from the NIMH. CK has received grant funding from the National Institute of Health, the MRC, MQ: Transforming Mental Health (UK), Royal Academy of Engineering (UK), Academy of Medical Sciences (UK), Conselho Nacional de Desenvolvimento Científico e Tecnológico (Brazil), and Fundação de Amparo à Pesquisa do Estado do Rio Grande do Sul (Brazil). CK has received consulting fees from UN Children's Fund. CK is the founder of a digital mental health platform, Wida. SS has received consulting fees from McKinsey Health Institute for work related to mental health. All other authors declare no competing interests.

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